Department of Vermont Health Access
Multiple Sclerosis Self Injectables
PRIOR AUTHORIZATION REQUEST

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
Date of Birth	Sex M ☐ F ☐	Medicaid ID#
Allergies: ☐ NKA or _____		
Street Address	City	
State	County	Zip Code
Home Phone	Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone
Emergency Contact	Relationship	Telephone
PRESRCIBER'S INFORMATION		
Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address	City	
State	County	Zip Code
Contact Person at Office	Prescriber Specialty	

Please Fax Completed for to:
Fax Number1-800-218-3221
Phone Number 1-866-843-3604

Patient Diagnosis:

Does the patient have relapsing forms of multiple sclerosis (including relapsing-remitting multiple sclerosis and progressive-relapsing multiple sclerosis)? ☐ Yes ☐ No

List previous medications/therapies tried and failed for this condition:

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments:

Product:

☐ Copaxone (Glatiramer) 40 mg/ml Prefilled Syringe (12 per carton)
☐ Extavia (Interferon beta-1b) 0.3 mg Prefilled Syringe (15 per carton)
☐ Glatopa (Glatiramer)20mg/ml Prefilled Syringe (30 per carton)
☐ Plegridy (Peginterferon beta-1a) Starter Pack **PEN** (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose (**Therapy initiation ONLY- NO refills)**
☐ Plegridy (Peginterferon beta-1a) Prefilled **PEN** 125 mcg/0.5ml (2 per carton)
☐ Plegridy (Peginterferon beta-1a) Starter Pack **SYRINGE** (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose (**Therapy initiation ONLY- NO refills)**
☐ Plegridy (Peginterferon beta-1a) Prefilled **SYRINGE** 125 mcg/0.5ml (2 per carton)

(Please Note: This form not to be used for Tysabri PA request or ordering)

Quantity:	**Refills:**

Dose/Route/Frequency Instructions (Sig):

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic
☐ Needles/syringes: quantity sufficient for drug supply with refills as above

Prescriber's Signature: _____Date: _____